



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
1201 LAKE WOODLANDS DR STE 4024
THE WOODLANDS TX 77380

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-2442-01

MFDR Date Received

MAY 21, 2013

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
MAY 31, 2012	EMERGENCY ROOM SERVICES	\$253.80	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

Per 28 Texas Administrative Code §133.20(j)(1)(C), a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the right to medical dispute resolution as provided by Labor Code §413.031. Review of the submitted information finds that the requestor submitted the medical bill for the services in dispute to the injured worker's employer. The Division therefore concludes that the requestor has waived the right to medical fee dispute resolution.

Conclusion

The requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the medical fee issues have not been addressed. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties, and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 28, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.